Request for SEMAT Services

Office Use Only

Job Summary:	Job Number:
Date Received:	Date Closed:

Details of the person being referred:

Name: _____

Date of Birth: _____ **Gender:** Male ☐ Female ☐ Other ☐

Address: _____

_____ **Postcode:** _____

Mobile Phone: _____ **Email:** _____

Home Phone: **Diagnosis:**

Preferred Contact Method: Home phone ☐ Mobile ☐ Email ☐

Current Chair:

Manual/ Power: **Brand:** _____

Dimensions:
(seat depth, back height, width) _____

Parent/Guardian/Person Responsible Details:

Relationship: Self ☐ Parent/ Guardian ☐ Spouse ☐ Carer ☐ Other ☐

Name: _____

Address: (if different from above) _____

_____

Telephone: Home: _____ Work: _____

Mobile: Email: _____

MAIN REASON FOR REFERRAL:

Assessment for new equipment ☐ **Review of existing equipment** ☐

Customisation of existing equipment ☐ **Repairs/Maintenance to existing equipment** ☐

If you are requesting an assessment for a new piece of equipment, what type of equipment do you need?
Eg: power wheelchair, commode etc.

_____

1.Presenting problem:

2.Client Seating or equipment goal(s):

Is English the main language spoken at home? Yes ☐ No ☐

If no is an interpreter need Yes ☐ No ☐ If yes in which language?

Is the person aware of the referral: Yes ☐ No ☐

If the referral is for a child, are there any Court Orders or Parenting Orders in place?

Yes ☐ No ☐

If YES, please provide details of the arrangement(s). You will need to provide a copy at the first appointment:

Referring Agent *(if applicable):*

Name:

Position/Organisation:

Address:

Postcode:

Telephone: **Email:**

Will you be attending the appointment? Yes ☐ No ☐

Funding being used to access SEMAT services :

☐ **DHHS/TasEquip**

☐ **Self Funding/Private**

☐ **MAIB**

Claim Number:

☐ **Other**
(please state)

☐ **NDIS**

NDIS Number:

Plan Expiry Date:

Support Item Number

Support Co-ordinator

Is your NDIS plan self-managed? Yes ☐ No ☐

Seating Identification Tool (SIT)

WITHIN THE LAST FOUR (4) WEEKS: (please circle)	**Yes**	**No**
1. Has the individual had red areas on their bottom?	2	0
2. Has the individual had an open pressure sore on their bottom?	2	0
3. Has the individual had red areas on their back?	1	0
4. Has the individual had an open pressure sore on their back?	2	0
5. Has the individual reported or demonstrated behaviour's that indicate they could be discomfort or pain while sitting for any length of time? (*such as moaning, grimacing or agitation*)	1	0
6. Has the individual had difficulty propelling their wheelchair? (*If the individual does not propel their wheelchair circle 0*)	1	0
7. Has the individual required repositioning as a result of sliding or leaning?	1	0
8. Has an anti-slide device such as a foam bolster, pommel, posture pal, or posey restraint been used?	1	0
9. Has the individual not been using wheelchair seat cushion? (*Do not include linens, pillows, incontinence pads or home made foam cushions*)	1	0
10. Has the individual tipped their wheelchair or been at risk of tipping their wheelchair?	1	0

Signature of referrer: _____ **Date:** _____

Return to:
SEMAT
StGiles
PO Box 416
Launceston TAS 7250

semat@stgiles.org.au
☎ 03 6345 7332
Fax: 03 6345 7373